APPEAL NO. 030871
FILED MAY 20, 2003

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing was held on March 24, 2003. The hearing officer determined that: (1) the date of maximum medical improvement (MMI) is June 25, 2000; and (2) the appellant's (claimant) impairment rating (IR) is 14%. The claimant appeals the IR determination on sufficiency of the evidence grounds, and asserts that the respondent (carrier) did not timely dispute the designated doctor's report. The carrier urges affirmance.

DECISION

Reversed and remanded.

It is undisputed that the claimant sustained a compensable injury to his lumbar spine on _____. He underwent a two-level fusion with hardware at L4-5 and L5-S1 in January 1999. The claimant experienced ongoing back pain with radiculopathy into both legs. Medical records show that the claimant had a grossly antalgic gait, give-way weakness in both legs, and was spending most of his time in bed. The medical evidence also indicates that the claimant began complaining of bladder incontinence and sexual dysfunction following his initial back surgery.

The parties stipulated that the claimant reached statutory MMI on June 25, 2000. The claimant's pain management doctor assigned a 14% IR, comprised of 3% for loss of lumbar range of motion (ROM) and 11% under Table 49 (II)(F) of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). A designated doctor was subsequently appointed by the Texas Workers' Compensation Commission (Commission). The designated doctor certified the claimant with a 68% IR, comprised of 28% for loss of lumbar ROM, 11% under Table 49 (II)(F) of the AMA Guides, and 50% for a spinal cord injury pursuant to page 99 of the AMA Guides. The designated doctor's report provides:

> Examination of the lower extremities shows hyper-reflexia of both patella reflexes and the left achilles reflex. The right achilles reflex is absent. Babinski sign is down going bilaterally. There is a sensory deficit to light touch and pin prick from the waist down. There is no sacral sparing. The patient is incontinent of bowel and bladder and in fact stuffs his under ware [sic] with large amounts of toilet paper to accommodate. I cannot appreciate any pressure ulcers. Manual muscle testing reveals 4 minus strength of hip flexors, 3+ strength of knee extensors, 2 out of 5 knee flexors and 1 out of 5 plantar and dorsi flexors.

> There is obvious muscle wasting in both lower extremities and we can appreciate some fasciculations in the intrinsic muscle of the feet.
>
> Although this patient has a documented right S1 radiculopathy with absent reflex, this impairment is overlapped by what appears to be a L2/L3 Franco classification C spinal cord injury. This is rated based on a Table on Page 99 of the Guides. He is a Category III and assigned 50 % whole person points.

The carrier subsequently submitted a peer review report, which challenged the designated doctor's ratings for loss of ROM under Table 49 of the AMA Guides. The peer review doctor also opined that there was no objective medical documentation to support the designated doctor's IR for spinal cord injury under page 99 of the AMA Guides. The Commission requested clarification of the designated doctor's certification, in view of the peer review report. The designated doctor maintained his IR and stated, with regard to the rating for spinal cord injury:

> I don't think that any of the previous examining physicians applied the Table on page 99 to this patient's spinal cord injury. As the examining physician, I made this determination based on my history examination and my clinical experience . . . . I understand the carriers [sic] concern with an excessively high impairment rating on a patient with a documented spinal injury.
>
> I would be pleased to perform a somatosensory of both potential study [sic] to give objective evidence of the patient's spinal cord level and pathology, however, this test really could not be applied to the Table on page 99, to decrement [sic] the number.

The claimant underwent a second spinal surgery, on April 9, 2002, including a repair of the fusion at L4-5 and L5-S1 and implantation of a bone stimulator. The carrier subsequently submitted a second peer review report. The report challenged the designated doctor's ratings for loss of ROM, recommended a higher rating under Table 49 of the AMA Guides, and asserted that there is no medical evidence of a spinal cord injury to support a rating under page 99 of the AMA Guides. The hearing officer determined that the claimant had a 14% IR, as certified by his pain management doctor, in the absence of any objective clinical and laboratory findings of a spinal cord injury warranting a 50% rating as assigned by the designated doctor under page 99 of the AMA Guides.

As indicated above, the claimant asserts that the carrier waived its right to contest the designated doctor's report by not raising a dispute within a reasonable time and for a proper purpose. The claimant cites Texas Workers' Compensation Commission Appeal No. 991012, decided June 25, 1999, and similar cases. The cases cited do not stand for the proposition asserted. Rather, the decisions apply a "reasonable time and proper purpose" analysis to determine whether a designated

doctor's amended MMI/IR certification was entitled to presumptive weight, prior to the amendment of Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.6(i) (Rule 130.6(i)). We are aware of no authority in which the carrier may be found to have waived a dispute of the claimant's IR under the facts of this case.

The hearing officer erred in adopting a 14% IR, as certified by the claimant's pain management doctor. Under Section 408.125(e), the report of the Commission-selected designated doctor is entitled to presumptive weight unless it is contrary to the great weight of the other medical evidence. The evidence shows that the claimant suffered from obvious muscle wasting in both lower extremities, fasciculations in the feet, a grossly antalgic gait, and that he complained of bladder incontinence as a result of his compensable injury and following his initial spinal surgery. Pursuant to Rule 130.1(c)(3)(F), the designated doctor was "responsible for referring the employee to another doctor or health care provider for testing, or evaluation, if additional medical information is required" for assigning an IR. Similarly, we have said that a designated doctor is required to rate the claimant's total impairment. *See* Texas Workers' Compensation Commission Appeal No. 980996, decided June 22, 1998. The designated doctor, in his response to the Commission's request for clarification, indicated that he was willing to perform the necessary tests to substantiate the rating for a spinal cord injury under page 99 of the AMA Guides. Under the circumstances of this case, we believe it was appropriate to seek further testing and clarification from the designated doctor with regard to the claimant's spinal cord pathology and rating, if any. Accordingly, we reverse and remand the hearing officer's determination for further consideration of the claimant's IR.

On remand, since the designated doctor previously appointed is now deceased, a new designated doctor must be appointed. *See* Rule 130.5 and Texas Workers' Compensation Commission Appeal No. 030737, decided May 14, 2003. The designated doctor should examine the claimant and determine his entire IR. In accordance with Rule 130.1(c)(3), the designated doctor should perform further testing to determine the existence of spinal cord pathology, if any. The designated doctor should include a description of how the findings relate to and compare with the criteria described in the applicable chapter of the third edition of the AMA Guides.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Commission's Division of Hearings, pursuant to Section 410.202 which was amended June 17, 2001, to exclude Saturdays, Sundays, and holidays listed in Section 662.003 of the Texas Government Code in the computation of the 15-day appeal and response periods. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

The true corporate name of the insurance carrier is **PACIFIC EMPLOYERS INSURANCE COMPANY** and the name and address of its registered agent for service of process is

ROBIN MOUNTAIN
ACE USA
6600 EAST CAMPUS CIRCLE DRIVE, SUITE 200
IRVING, TEXAS 75063.

_____
Edward Vilano
Appeals Judge

CONCUR:

_____
Chris Cowan
Appeals Judge

_____
Michael B. McShane
Appeals Panel
Manager/Judge